

STATE OF CALIFORNIA BUSINESS TRANSPORTATION AND HOUSING AGENCY
DEPARTMENT OF CORPORATIONS, HEALTH CARE DIVISION, COMPLAINT FORM

**PLEASE READ THE INSTRUCTION SHEET PRIOR TO COMPLETING THIS FORM.
PLEASE TYPE OR PRINT CLEARLY AND COMPLETE ALL ITEMS ON THIS FORM.**

1. Your full name (identifies you as the complainant): _____
2. Your street address (residence): _____
City: _____ State: _____ Zip: _____
3. Telephone: Home () _____
 Work () _____
4. Complete Name of Health Plan: _____
5. Address: _____
City: _____ State: _____ Zip: _____
6. Subscriber's complete name if different from your name: _____
7. Subscriber's identification number: _____
8. If group coverage, name of group: _____
9. Have you previously written to the Department of Corporations about this specific matter? If yes, please give:
File number: _____ Date Written: _____
10. Have you reported this to other governmental agencies?
Yes____ No____
If yes, please state name of agency and its file number:

- 10a. Are you a Medi-Cal beneficiary? Yes____ No____
Are you a Medicare beneficiary? Yes____ No____
11. Do you have an attorney representing you? Yes____ No____

12. Is there a civil action (lawsuit) pending? Yes___ No___
If yes, state the name of the county, case number, date
filed: _____

* Please also attach a photocopy of the court documents.

13. Have you contacted the health plan complained about?
Yes___ No___
If yes, state the date(s) and person(s) contacted: _____

14. Do you know whether the health plan has a grievance system?
Yes___ No___
If yes, have you used it? Yes___ No___

15. This information provided is furnished voluntarily. I
understand it is not mandatory that I furnish the requested
information, but failure to do so may delay or even preclude
further consideration of my complaint.

16. I understand that a copy of this complaint may be sent to
the health plan.

17. Stated as briefly as possible, the following are the
essential facts (including, "who, what, where, when and how")
of my complaint (use additional paper if needed):

Date:_____Signed: _____
If you have any questions concerning this form, please call
our toll free number 1-(800)-400-0815.

After you complete the form and attach a photocopy of all of
the documents and records, please mail them to:

Department of Corporations
Health Care Division
Consumer Services Representative
3700 Wilshire Boulevard
Los Angeles, CA 90010-3001